MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
SPECIAL EDUCATION-FUNDS MANAGEMENT

HOMEBOUND INSTRUCTION APPLICATION

DESE USE ONLY
DATE RECEIVED:_____
APPROVED ☐ YES ☐ NO
OF WEEKS APPROVED_____

I. STUDENT INFORMATION ☐ Student with an IEP ☐ Nondisabled

Date of Application: ☐ Initial ☐ Extension (Circle One) 1 2 3

Type of Application: ☐ Medical ☐ Reevaluation ☐ Suspension/Expulsion ☐ Other:

Name of Student: DOB: Grade:

Name of Parent/Guardian:

Home Address:

II. SCHOOL DISTRICT INFORMATION

1. Teaching completed by: ☐ Phone ☐ Home teaching ☐ Other:

2. Estimated total length of homebound services: _____weeks (length of service must be given in weeks; if less than 9, DESE Approval Not Needed)

Name of Teacher	Social Security Number	Area(s) of Certification	
Legal Name of Educational Agency	District Contact Person	Telephone	Fax
Address	City	State	Zip Code

III. EDUCATIONAL INFORMATION (To be completed by Director/Coordinator of Special Services) (N/A if Medical, complete Section IV)

1. Are you requesting a reevaluation? ☐ Yes ☐ No (If yes, enclose copy of Notice of Reevaluation)

2. Has the IEP Team met? ☐ Yes ☐ No (If yes, date: _____)

3. Has this student been suspended or expelled? ☐ Yes ☐ No (If yes, enclose copy of Change of Placement and Manifestation Determination)

4. Is this student not attending due to a court injunction? ☐ Yes ☐ No (If yes, attach copy of court order)

IV. MEDICAL INFORMATION (To be completed by Physician) (N/A if Educational, complete Section III)

1. Does condition prevent student from maintaining school schedule? ☐ Yes ☐ No

2. Medical or Psychological Diagnosis:
If pregnant, please indicate due date: _____

3. Number of weeks student will require homebound: Date of hospitalization:

4. Recommendations and explanations of diagnosis: (NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible.)

Signature of Physician	Date	Print Physician's Name	
Address of Physician	State	Zip	Phone

Indicate Area of Licensed Specialty: ☐ M.D. ☐ D.O. ☐ Psychiatrist ☐ Psychologist

V. CERTIFICATION (To be completed by the School District)

I CERTIFY THAT A NEED FOR HOMEBOUND SERVICE EXISTS AND THE PROVISION OF HOMEBOUND INSTRUCTION IS THE MOST APPROPRIATE EDUCATIONAL ALTERNATIVE AT THIS TIME.

Superintendent or Authorized Representative	County/ District Code	Date

The district must maintain a copy of the application on file for a period of 5 years. These applications will be monitored as a part of the district's Special Education MSIP Review. For Homebound applications requiring Department of Elementary and Secondary Education approval, a letter will be returned to the district for their records.

MEDICAL PERSONNEL
Mail or fax form to the school district where the child is enrolled.
NOTE: In the case of emotional disorders, a treatment plan should be designed to encourage the re-entry of the student into regular school environment as soon as possible

DISTRICT PERSONNEL
Mail or fax completed form to:
Missouri Department of Elementary and Secondary Education
Division of Special Education, Funds Management Section
PO BOX 480, Jefferson City, MO 65102-0480
Office: 573-751-0622– Fax: 573-526-4404